



**CLAIM FOR DISTRIBUTION OF CONTRIBUTIONS
1977 POLICE OFFICERS' & FIREFIGHTERS'
PENSION & DISABILITY FUND**

State Form 947 (R5 / 10-08)

**1977 POLICE OFFICERS' & FIREFIGHTERS'
PENSION & DISABILITY FUND**
143 West Market Street
Indianapolis, Indiana 46204-2899

* This agency is requesting disclosure of Social Security Numbers in accordance with Internal Revenue Code; disclosure is mandatory and this form will not be processed without it.

INSTRUCTIONS:

1. Please type or print. Use black ink.
2. Complete all information.
3. Return the completed form directly to the 1977 Fund. **Do not return the instruction pages.**

NOTICE: Federal and State law prohibit the 1977 Police Officers' and Firefighters' Pension and Disability fund (1977 Fund) from making distributions from the Fund prior to your separation from employment. Uninterrupted service or re-employment in any capacity prevents the 1977 Fund from making a distribution to you. This includes a continuation of employment in any capacity, full-time or part-time, in any agency or department of your current employer, either in a position covered by the 1977 Fund or in any position not covered by the 1977 Fund. In addition, you should not complete this form if you intend to become re-employed in a 1977 Fund covered position with any employer.

STEP 1 - MEMBER INFORMATION

Social Security Number *		Date (month, day, year)
Name of member (first, middle initial, last)		
Address (number and street, city, state, and ZIP code)		
Home telephone number ()	Other telephone number ()	E-mail address

STEP 2 - ELECTION FOR ROLLOVER ACCOUNT PAYMENT

I elect a complete distribution of my rollover account as follows (select only one):

☐ Direct rollover ☐ Paid directly to me (less withholding) ☐ Partial rollover in the amount of \$ _____, balance (less withholding) paid to me.

Name of eligible 401(a), 403(b), or governmental 457(b) retirement plan or traditional IRA (complete only if you select a rollover).
(This must be the complete name of the eligible plan or traditional IRA as reported by the trustee to the Internal Revenue Service.)

STEP 3 - ELECTION FOR INCOME TAX WITHHOLDING

State tax: I do not want State income tax withheld from my distribution.

Signature of member	Date (month, day, year)
Printed name of member	

STEP 4 - MEMBER AFFIDAVIT

I, having been sworn, hereby submit this Claim for Distribution of Contributions and say under oath that:

I am the person who completed this distribution application;

I have carefully read the form and understand the same, and that I have read all of the information I have been provided with this application, including all instructions and supplemental documents;

All the information I have provided and the questions I have answered are full, complete and true, and no material facts have been concealed or omitted therefrom; I understand fully that, once this claim has been processed by the 1977 Fund and I have received a distribution check or warrant, this transaction cannot be voided by a return of the check, warrant, or money. I agree that, by the acceptance of this distribution, I relinquish any and all claims for service that may have accrued to me through membership in the 1977 Fund, unless I repay all amounts distributed to me in accordance with the applicable statutes and rules.

I further certify that I am not continuing uninterrupted employment in any capacity, full-time or part-time, in a 1977 Fund covered position or a position not covered by the 1977 Fund in any agency or department of my current employer.

I understand that my choice for payment of my rollover account cannot be changed after this form is received by the 1977 Fund.

By signing below, I acknowledge that I have read and understand this statement.

Signature of member	Date (month, day, year)
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CERTIFICATION OF NOTARY PUBLIC

STATE OF _____	
COUNTY OF _____	SS: _____
Subscribed and sworn to before me, a notary public, in and for the state and county above named, by the said _____, on this _____ day of _____, 20____.	
_____ Printed name of member	
Signature of notary public	Printed name of notary public
County of residence	Date commission expires (month, day, year)

Employer's Report of Separation from Employment

First Name	MI	Last Name	Social Security Number
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Federal law prohibits PERF from making distributions from the fund prior to "separation from employment." Uninterrupted service in any capacity or reemployment that is a continuation of employment will prevent PERF from making distributions to the employee.

Last Day in Pay Status

Please fill this out during the employee's exit interview.



The last day in pay status is needed to process this member's benefit. Last day in pay status is the last day for which this employee was entitled to receive his or her regular wages. Regular wages paid may include pay for a day worked, a sick day, vacation day or another paid leave permitted under your personnel policy. The last day in pay status and the last check date are typically different.

The last day in pay status (MM/DD/YYYY): _____

The last check date, if known (MM/DD/YYYY): _____

Did the employer-employee relationship extend beyond the last day in pay status? ☐ Yes ☐ No

If the relationship continued, please explain: _____

School Employers Only

Please indicate the type of school service being reported. Be sure to check the appropriate box below indicating whether the employee should receive full credit, contract credit or credit for time worked. Members who were hired after the beginning of the school year or terminated before the end of the school year cannot earn a full year of service unless they were under a specific contract that kept them from working the entire school term.

☐ School Year Credit (full year) ☐ Contract Year Credit (full year) ☐ Service Credit for Time Worked (partial year)

Authorization to be Signed by Authorized Agent

I certify that the above information is true and accurate to the best of my knowledge and that I am the individual formally authorized to accept any pension liability for and on behalf of the governing body of this employer. I understand that any error in this certification of service can only be corrected prior to the processing of the member's benefit application.

Sign
Here

Signature of Authorized Agent	Printed Name of Authorized Agent
Title of Authorized Agent	Date
Name of Employer	Employer Account Number



Upon completion, please mail to PERF: 143 West Market Street, Indianapolis, IN 46204. Or fax this page to: (317) 234-1226.
Page four is the ONLY one that may be faxed. Pages one through three must be mailed to PERF.